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	185178	A. BUILDING _____ B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTOPHER EAST HEALTH CARE CENTER	4200 BROWNS LANE LOUISVILLE, KY 40220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 273	Continued From page 20 completed as she was behind on completing assessments.	F 273	completion date and responsible staff member. The facility will designate a back-up MDS nurse to assist in timely completion of the MDS in the following circumstances including, but not limited to vacation, volume, or illness to ensure compliance with the process. The MDS Coordinator, ADNS or her designee will monitor the MDS schedule using intra-facility technology. The MDS Coordinator is to report to the ADNS and Assistant Administrator any issues of perceived non-compliance and/or timeliness. **How does the facility plan to monitor its performance to ensure that solutions are sustained?** – Compliance with this process will be monitored monthly by the facility QAA Committee until issue is deemed resolved.	
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to prevent an avoidable decline in ambulatory ability for one (1) of twenty-five (25) sampled residents in accordance with the Comprehensive Assessment. The facility failed to prevent an avoidable decline in the ambulatory ability of Resident #17. The findings include: The facility completed the MDS assessment on 04/08/10 and Resident #17 was evaluated as cognitive status of one (1), and the ambulatory status was eight (8) for ambulation in room and hall, indicating Resident #17 was not ambulatory at the time of the MDS assessment on 04/08/10. The MDS assessment on 06/30/10 for Resident #17 indicated the cognitive status remained one (1), with improvement in ambulatory status as three (3) indicating the resident ambulates in the			

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F 310	Continued From page 21 room and hall with extensive assistance of one person. Upon review of the Physical Therapy Summary dated 05/12/10, Resident #17 was discharged from Physical Therapy. The resident's functional status on 05/12/10 was for minimal assist with bed mobility, minimal assist of caregiver for sitting to standing, chair to wheelchair, and to toilet. The resident's gait status on 05/12/10 was noted as 40 to 50 feet with minimal assist of one caregiver with rolling walker. The plan stated the resident appears to reach maximum potential with functional mobility, and plan to refer to Nursing to establish a restorative program. Upon review of the Therapy Follow Up Communication note, the recommendations were for the resident to walk to dining room with rolling walker once a day with a gait belt and a one person physical assist. Also noted was transfer from bed to chair and transfer from chair to bed requires a one person physical assist. Review of Rehabilitation Screening dated 06/29/10 noted the resident was observed ambulating to dining room with walker and stand by assist of a CNA. The note stated the resident appeared steady and the recommendation was to continue the restorative program. Observation performed with Resident #17 ambulating to Dining Room for lunch on 07/15/10 at 11:45am with the assistance of LPN #4 and CNA #1. LPN #4 and CNA #1 assisted Resident #17 to stand from a sitting position in a wheelchair and ambulate with a rolling walker. The resident displayed unsteady gait as evidenced by both staff members holding the walker on each side while pulling the wheelchair behind the resident. Resident #17 ambulated twenty-five (25) feet and asked how much more	F 310	**F310** The facility continues to ensure that, based on the comprehensive assessment of a resident, the facility ensures that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom' transfer and ambulate' toilet, eat' and use speech, language or other functional communication systems. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** – Resident #17 was re-evaluated by the physical therapy department on 8/4/10 and the resident demonstrated an ability to ambulate 100 feet. Physical therapy determined that there was no decline in the patient's functional abilities and recommended that the facility continue with the established restorative programming. **How will you identify other residents having the potential to be affected by the same deficient practice?** - All residents have the potential to be effected by this deficient practice.	8/27/10

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F 310	Continued From page 22 he/she had to walk. LPN #4 stated they would just take the resident to the bathroom, which is halfway to the dining room. Interview with Resident #17, on 07/15/10 at 11:30am, revealed the resident did not walk to the dining room often. When asked the last time the resident ambulated to the dining room for a meal, the resident responded, last Sunday. The resident correctly identified the current day of week as Thursday. The resident stated walking more often would be enjoyed, if it was safe. Upon being approached by LPN #4 and CNA #1 to ambulate to lunch on 07/15/10 at 11:45am, the resident stated he/she usually goes to the dining room in the wheelchair and that he/she has not gone that far. CNA #1 responded that they had walked as far as the dining room before. During an interview with the Unit 200 Manager, on 07/15/10 at 2:01pm, the manager explained the restorative program and documentation. The Unit Manager stated the resident got up for all meals and ambulated to the dining room unless the resident declined. The Director stated Resident #17 walked back to his/her room after lunch in the dining room today. Interview with Resident #17 on 07/15/10 at 2:40pm revealed the resident did not ambulate to his/her room after lunch. Resident #17 stated, they pushed "me" in the wheelchair and CNA #2 confirmed that she did push Resident #17 back to the room after lunch. An interview with the Activities Director on 07/15/10 at 2:45pm revealed the resident is not involved in activities that involve walking which would promote the resident's maximum level of	F 310	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** – All residents in restorative programming will be screened by nursing for change in status and presented to physical therapy re-evaluation should it be suspected a decline in functional status has occurred. Based on the findings, individual restorative programming will be amended to meet patient need. **How does the facility plan to monitor its performance to ensure that solutions are sustained?** – All residents in restorative programming will be reviewed weekly during the nursing clinical stand-up meeting. Any declines in status will be reported to the Unit Manager for referral to Therapy services. All identified declines will be reviewed monthly during the facility QAA meeting until issue has been deemed resolved.	

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F 310	Continued From page 23 functioning for increased independence. The Activities Director stated during One-on-One visits an object might be passed to the resident, and then passed back and forth.	F 310		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions as evidenced by black greasy substances built up in the ovens and cook top back splash. The findings include: Observations of the kitchen ovens and cook top back splash on 07/13/10 at 8:10am revealed there was a black greasy appearing substance on the floor and on the racks of two stacked ovens and two stove ovens. The back splash behind the stove cook top had a large area of brown and black substance that appeared greasy. Interview with dietary aide #1 on 07/13/10 at 3:30pm revealed the ovens and cook top are	F 371	**F371** It is the practice of this facility to (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) store, prepare, distribute and serve food under sanitary conditions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** – The kitchen ovens and cook top back splash were cleaned and re-inspected on 7/14/10. In addition, the cleaning of these areas was incorporated into the department's routine cleaning schedule. **How will you identify other residents having the potential to be affected by the same deficient practice?** - All residents have the potential to be effected by this deficient practice.	8/27/10

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F 371	Continued From page 24 cleaned once a week. Interview with the dietary manager on 07/13/10 at 3:40pm revealed there was a monthly dietary cleaning schedule and items listed on the schedule were routinely cleaned. Review of the cleaning schedule revealed the cleaning of the ovens and back splash were not included on the schedule.	F 371	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** – Routine monitoring of these areas as well as all required cleaning tasks will continue to be monitored by the food service manager and the dieticians, in accordance with the defined cleaning schedule. **How does the facility plan to monitor its performance to ensure that solutions are sustained?** – Reports of the dietary manager and/or dietician findings will be submitted to the facility QAA Committee on a monthly basis until deemed resolved.	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain essential resident care equipment in safe operating condition. Two (2) of four (4) nursing units, the 100 hall and 200 hall, failed to ensure glucometers were tested on a daily basis with the glucose control solution to ensure proper functioning of the glucometer per facility policy and manufactured recommendation. The findings include: A review of the facility policy on quality control testing of the glucometers revealed that the facility had no policy, but used the manufactures recommendations for Quality Control testing of the glucometer. The Manufactures recommendations for the Assure 4 Meter revealed that depending on state regulation, control solution testing may be required on a daily		**F456** It is the practice of this facility to maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	8/27/10

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F 456	Continued From page 25 basis, as per the local inspector's regulation or facility procedure. A review of the Glucose Monitoring System Quality Control Record on 07/15/10 at 10:15am, for the 200 hall revealed since 06/28/10 the Glucose Monitor was not tested with the control solutions on the following days: 06/30/10, 07/07/10, 07/08/10, 07/10/10, 07/11/10, and 07/13/10. Review of the Glucose Monitoring System Quality Control Record for the 100 hall revealed that since 07/01/10, two (2) glucose monitors had not been tested on the following days: 07/03/10, 07/04/10, 07/05/10, 07/08/10, 07/09/10, 07/10/10 and 07/14/10. An interview with the Unit Manager for the 200 hall on 07/15/10 at 10:15am revealed the Glucose Monitoring System should be tested with the control solution on a daily basis. She stated testing usually occurred on the night shift. She stated they did not keep the old quality control records. She further indicated they had just received the new Glucose Monitoring Systems within the last two weeks and the staff were in-serviced on the use of the machine and how to do the quality testing of the machine. An interview with LPN #4, on 07/15/10 at 11:05am, who works the day shift, revealed that she knew when the Glucose Monitoring System needed to be quality tested because a bell will be showing in the right corner, and when you turn the machine on it will show PCS (perform control solution). She stated if she sees this, she will do the control check, as evidenced by documentation on the record of 07/01/10. An interview with the Unit Manager on the 200	F 456	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** – The issue identified under this deficiency was addressed immediately by the Director of Nursing. The Unit Managers of each unit were advised via memorandum on 7/15/10 of their responsibility to monitor the Meter logs on a daily basis. **How will you identify other residents having the potential to be affected by the same deficient practice?** - All diabetic residents have the potential to be effected by this deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** – The facility Unit Managers or their designee will check the Blood Glucose Monitoring Meter Logs daily to ensure that all meters have been calibrated between the hours of 10pm and 6am. All licensed nurses and all weekend Nursing house supervisors will be re-educated on the importance of calibrating meters.	

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F 456	Continued From page 26 hall on 07/15/10 at 1:30pm revealed that the Glucose Monitoring Systems were to be checked daily, and this was not new to the facility, although the current Glucose systems have only been in use for about two (2) weeks. She stated it was important that the machines be checked to ensure the accuracy of the machine to read the resident's blood glucose.	F 456	**How does the facility plan to monitor its performance to ensure that solutions are sustained?** – The facility Unit Managers will report weekly to the Director of Nursing any negative findings and corrective action taken to ensure compliance to this process. The Director of Nursing will report findings to the facility QAA Committee monthly until issue has been deemed resolved.	

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 07/15/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F ".	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure exits were maintained according to NFPA standards. The findings include: Observation on 07/15/2010 at 2:15 PM, revealed that the 200 short hall way exit required a two step process to unlock the exit. Interview on 07/15/2010 at 2:15 PM, with the Maintenance director, revealed that to exit from the 200 short hall, the person exiting must push a button located on the wall then turn a knob on the door. Reference: NFPA 101 (2000 edition) 7.2.1.5.4	K 038	K038 It is the practice of this facility to ensure that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Facility disabled turn lock to eliminate two step process to unlock exit door on 200 short hall. **How you will identify other residents having the potential to be affected by the same deficient practice** – All residents have the potential to be effected by this deficiency.	08/03/10
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Julie Buck Williams	X Administrator	8/6/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 10 2010

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K 144 SS=F	Continued From page 1 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that the emergency generator is maintained according to NFPA standards. The findings include: Observation on 07/15/10 at 2:47 PM revealed that the facility did not have a remote annunciator for the emergency generator in a location that was continuously monitored. The remote annunciator for the emergency generator was located in the maintenance shop. The Maintenance Director was present during the observation. Interview on 07/15/10 at 2:47 PM, with the Maintenance Director, revealed that the maintenance shop was not continuously monitored. Reference: NFPA 99 (1999 edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the	K 144	**What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur** – The maintenance director, or his designee, will inspect all exit doors daily to ensure exits are easily accessible. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – The facility will continue to inspect exits to ensure they are readily accessible. Any issues will be reported to the Facility CQI Committee. K144 It is the practice of this facility to ensure generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Facility contractor for generator reviewed system and noted remote annunciator for generator already existed at the 300/Pathways Nurses Station and functioned properly. Maintenance, Administration and Nurses on 300/Pathways unit reeducated on system.	08/03/10

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K 144	Continued From page 2 generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144	**How you will identify other residents having the potential to be affected by the same deficient practice** – All residents have the potential to be effected by this deficiency. **What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur** – System was performing properly and no systemic changes needed. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – Facility will continue to perform generator inspections and any adverse findings will be reported to the facility CQI committee.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	K147 It is the practice of this facility to ensure that electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2.	08/25/10

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K 147	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure circuit breaker boxes were locked to prevent access from unauthorized persons. The findings include: Observation on 07/15/2010 at 11:45 Am, revealed that the 100 hall corridor had (2) circuit breaker boxes and (1) panel for the timer of the outside lights, that were unlocked. Further observation revealed that the 400 hall corridor had (2) circuit breaker boxes that were unlocked. The Maintenance Director was present during the observation. Interview on 07/15/2010 at 11:45 AM, with the Maintenance Director, revealed that he was unaware of the requirements for the circuit breaker boxes. Reference: NFPA 70 (1999 Edition), 110-26.	K 147	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** – Facility has locked all circuit breaker boxes and panels for outside light timers. **How you will identify other residents having the potential to be affected by the same deficient practice** – All residents have the potential to be effected by this deficiency. **What measures will be put into place, or what systemic changes you will make to ensure that the deficient practice does not recur** – Maintenance Department will inspect monthly when checking emergency lighting in facility. **How the corrective action(s) will be monitored to ensure that solutions are sustained** – Any issues from Maintenance inspections will be reported to the CQI committee.	